Passion for Healing Naturopathic Pediatric Intake Form

Name_____ Date of birth _____ Age _____ Birth gender M or F

Grade of School:_____

Address: _____

City:_____State:_____Zip:_____

Mother's Name and occupation:_____

Father's Name and occupation:_____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Who does the child live with:_____

Emergency Contact:_____

Reason for Office Visit:_____

_____

How long has this gone on for?_____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

What other treatments have been attempted?_____

What was the result with these treatments?_____

What factors may be contributing to this problem?_____

Please list name and city of any Pediatrician:_____

Does your child have a contagious disease at this time? Y N If yes, what? _____

Hospitalization, Surgery, Imaging Please list dates of any hospitalizations, surgeries, procedures, X-Rays, CAT Scans, MRIs, Bone density scans, EEG, EKG's or other imaging that the child has had:

_____

_____

_____

Has the child ever been to the emergency room? Y N What was it for?_____

_____

Laboratory Has child had any blood work done? If yes, please list what:

_____

Allergies or Hypersensitivities

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

Last Name_____ First Name_____

Current Medications Please list all prescription medications and over-the-counter medications the child takes:

_____

_____

_____

Past Medications What other medicines has the child taken? How often?

_____

_____

Supplements Please list all supplements child is taking:

_____

_____

Childhood Illnesses Please circle whether the child has had any of these:

Scarlet fever Diphtheria Rheumatic fever Mumps Measles German measles Rubella

Other: _____

Immunization History Y= Yes has had all recommended N=No has not S=some but not finish all

MMR: Yes No Some DPT Yes No Some Hep B: Yes No Some

Hib: Yes No Some Chickenpox: Yes No Some Polio: Yes No Some

Other vaccinations:_____

Any reactions to vaccinations? If so, please explain: _____

Current flu Shot? Y N

Family History Does the child have a family history of any of the following (please circle)?

Allergies Obesity Cancer Tuberculosis Cardiovascular disease Heart murmurs

Mental Illness Diabetes mellitus Asthma Allergies/Hay fever/Hives Anemia Epilepsy

Any other relevant family history? _____

General

Height: _____Weight (lbs): _____ Unexplained weight gain/loss? _____

Typical Food Intake Please describe a typical days worth of meals and snacks:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Deserts/Candy: _____

Water (cups): _____Juices: _____Milk/Soymilk _____

Does the child eat three meals a day? Yes No Has the child ever gone on a diet? Yes No

Does the child eat out often? Yes No If yes, how often? _____

Does the child eat refined sugars? Yes No Does the child eat fried foods regularly? Yes No

Does the child drink sodas, Cool Aid, sports drinks? Yes No Is the child a finicky eater? Yes No

Does the child eat artificially colored or flavored foods? Yes No

Does the child eat lunch meats/hot dogs preserved with nitrates? Yes No

Toxin Exposure:
Has the child ever lived near a factory or other highly polluted area?_____

Has the child ever lived in a house with lead paint?_____

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all?_____

Does anyone smoke in the home? _____ In child areas? _____

Has there ever been a problem with mildew in the home? _____

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

_____

Does the child seem particularly sensitive to perfumes or other vapors?_____

Habits For the following please circle

Y=Yes, a condition you have now N=No, never had P=Past problem

Main interests and hobbies:_____
Enjoys school? Y N Play with others? Y N Spends time outside? Y N Reads? Y N

Daycare? Y N Pets? Y N Age and gender of siblings: _____

Does the child have a religious or spiritual practice? Y N If yes, what?_____

Watch television? Y N Hours per day? _____ Video games/web surfing? Y N Hours per day? _____

Have a history of domestic abuse? Y N Have a history of sexual abuse? Y N

Exercise Does the child exercise? Y N How often? _____
If yes, what kind? _____

Sleep Average 8-12 hours sleep? Y N If no, how much? _____ Sleep well? Y N Awaken alert? Y N

Frequent nightmares? Y N Night terrors? Y N Sleep walking? Y N Bed Wetting? Y N
Very sweaty baby/child? Y N Regular naps? Y N

Review of Systems

Y=Yes, a condition you have now N=No, never had P=Past problem

Mental
Any speech impediments? Y N P Learning impediments? Y N P Developmentally disabled Y N P

Other: _____

Last Name_____ First Name_____

Emotional

Tantrums Y N P Excessively disobedient Y N P Fears/Phobia Y N Hyperactivity Y N P
Other: _____
Any particular household stressors child has witnessed or gone through:
_____
_____
_____

Neurologic
seizures Y N P Dizzy spells/fainting Y N P Muscle weakness Y N P Paralysis Y N P
Other: _____

Immune
Frequent flus/colds? Y N P If has had, how many total? _____ HIV/AIDS Y N

Slow wound healing Y N P Swollen glands Y N P Reactions to immunizations Y N P

Other immune problems:
_____

Endocrine
Diabetes Y N P Excessive thirst Y N P Excessive hunger Y N P
Other: _____

Skin
Warts Y N Cradle cap Y N P Eczema or psoriasis Y N P Diaper Rash Y N P Hives Y N P
Other: _____

Head
Meningitis Y N Headaches Y N P Head Injury Y N P

Other: _____

Eyes

Impaired vision Y N Glasses Y N Blindness Y N P
Vision Tests Normal: Yes No Not Tested
Other: _____
Ears
Hearing loss Y N P Ringing Y N P Earaches Y N P Dizziness Y N P
Ear Infections? Y N P If has had, how many total?_____ Antibiotics? Y N Ear tubes? Y N
Hearing tests Normal: Yes No Not Tested
Other: _____

Nose and Sinuses
Nose Bleeds Y N P Stuffiness Y N P Nasal drip Y N P
Other: _____

Mouth and Throat
Poor teeth Y N Strep throat? Y N P If yes, how many times?_____
How many times has the child taken antibiotics:_____
Other: _____

Last Name_____ First Name_____

Neck
Pain or stiffness Y N P Lumps Y N P Swollen glands Y N P Goiter Y N P
Other: _____

Respiratory
Asthma Y N Bronchitis Y N Pneumonia Y N Cystic fibrosis Y N
Other: _____

Cardiovascular
Heart murmur Y N Rheumatic Fever Y N P
Other: _____

Blood / Peripheral Vascular
Anemia Y N P Easy bleeding/ bruising Y N P Leukemia Y N P
Other: _____

Gastrointestinal
Jaundice (yellow skin) as baby Y N Colic Y N P Diarrhea Y N P Constipation Y N P
Stomach ache Y N P Appendicitis Y N Gas/Bloating Y N P Belching Y N P Worms Y N P
Other: _____

Urinary
Frequent urination Y N P Blood in urine Y N P Pain with urination Y N P Bedwetting Y N P
Other: _____

Musculoskeletal
Growing pains Y N P Small for age Y N P Hip displacement Y N P Joint pain Y N P
Broken bones Y N Scoliosis Y N P Cerebral palsy Y N Spina bifida Y N
Other: _____

Male specific
Early Puberty Y N Undescended testicle Y N Testicular torsion Y N
Other: _____

Female specific
Early Puberty Y N Have menses started? Y N Age began? _____ Cramps Y N PMS Y N
Other: _____

Mother's Pregnancy history
Age at conception:_____ Did she have other children already? Y N How Many? _____
Did she receive prenatal care Y N Prenatal vitamins Y N Adequate nutrition Y N
Health during pregnancy: Nausea/Vomiting Yes No Emotional Stress Yes No Illness Yes No
Smoking Yes No Coffee Yes No Recreational drugs Yes No Prescription drugs Yes No
Diabetes Yes No Preeclampsia/eclampsia Yes No Thyroid problems Yes No
Please circle if infant exposed to maternal: herpes rubella chicken pox cytomegalovirus toxoplasmosis
Vaginal birth Yes No Length of Labor:_____ Cesarean section Yes No Traumatic birth: Yes No If the birth was difficult, please explain: _____

_____

Health of baby at birth (APGAR scores):_____

Last Name_____ First Name_____

Breastfed? Y N For how long:_____

When put on formula_____ What formula was used:_____

When was infant put on solid food:_____What foods introduced

first:_____

When did child crawl:_____ When did child walk:_____ When did child talk:_____

Develop baby teeth:_____ Develop adult teeth:_____

Anything else you would like to add that we haven't asked you about? _____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time and effort.
Dr. Curry sincerely looks forward to meeting your family and fulfilling your health care needs and goals.

Last Name_____ First Name_____

Informed Consent for Naturopathic Medical Treatment

I, _____, hereby authorize Dr. Mindy Curry or other licensed doctors of naturopathic medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., laboratory, venipuncture, UA, Pap smears, radiography, allergy testing,
Minor medical procedures: e.g., ear cleansing, nail care, nasal specific, wound care, minor surgery,
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, IM vitamin injections, IV therapy,
Botanical medicine: botanical substances may be prescribed fresh or as teas, alcohol tinctures, syrups, powders, capsules, tablets, troches, creams, essential oils, gels, or suppositories,
Hydrotherapy: the use of water, warm, hot or cold to stimulate circulation, immune function, and relieve pain,
Naturopathic physical medicine: e.g. naturopathic manipulation therapies, Positional release techniques, Strain/Counterstrain, Post-Isometric Relaxation stretch, Physiotherapy,
Therapeutic massage techniques: heat and cold therapies, electric stimulation, manual therapies, energywork,
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses,
Environmental counseling: identification and removal of environmental obstacles to health, e.g., toxins, allergens.
Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction, balancing of work with social activities, art therapy and spiritual awareness,
Psychological counseling: Discussion of emotional concerns, origins thereof, and options for management,

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections, venipuncture, or physical medicine, aggravation of pre-existing conditions.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it (fees apply for subsequent copies).

_____	_____	_____
Printed Name of Patient	Signature	Date
_____	_____	_____
Printed Name of Legal Guardian	Signature	Date